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ABSTRACT

Substance abuse treatment has been demonstrated to be effective in reducing not only substance use, but also the economic, health, and social costs associated with substance abuse. This document examines how health care reform can preserve and enhance community substance abuse services. The cost effectiveness of funding substance abuse prevention activities is explored, and mechanisms for providing funding are suggested. The relationship between substance abuse treatment and health care reform is discussed. An overview of the substance abuse treatment system is provided. A panel of coalition leaders was formed to create financing for substance abuse treatment and the following recommendations were offered: (1) substance abuse treatment should be financed through the same sources that fund general health care; (2) prevention should be adequately financed through a combination of public and private sector funding sources; (3) the nation must make a commitment to adopt and enforce cost containment mechanisms to control the rise in health care costs; (4) there should be universal and timely access to substance abuse diagnosis and appropriate treatment services; (5) a broad continuum of substance abuse treatment services must be available to all; (6) substance abuse treatment should be managed and coordinated with essential human services to encourage the delivery of appropriate cost-effective care; and (7) standard health care benefits should cover the cost of clinical preventive education, brief intervention counseling, and/or referral for alcohol, tobacco, and other drug problems. Contains 17 references. (SR)

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ED 387 716

Health Reform for Communities:

Financing Substance Abuse Services

Recommendations
from a
Join Together Policy Panel

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Foreword by Calvin Hill

Calvin Hill

Local substance abuse coalition leaders tell us that too many people with alcohol and drug abuse problems in their communities do not have access to treatment. In response, Join Together convened a national policy panel on financing substance abuse services. The panel's work examines how health care reform can preserve, indeed, enhance our communities' substance abuse services. Their recommendations show that treatment for substance abuse in any health care reform is essential to permanently reduce crime, violence, family disruption, and economic losses from untreated substance abuse.

The orientation of most coalitions is local. Yet they are affected by forces at the state and national levels. The reform of our country's health care system will have greater impact on local substance abuse prevention, intervention, treatment, and recovery services than any other state or federal undertaking in many years. We hope the recommendations of this policy panel will help them get involved in the national policy debate. We believe community voices calling attention to the need for substance abuse must be heard above the din of narrower special interests.

The charge to Mayor Whitmire and her colleagues on the panel was to examine and put forth principles, priorities, and goals that should govern financing and organizing services for substance abuse. The panel met with and listened to community leaders and experts in health care. The panel's seven recommendations offer guidance to community leaders and policy makers as they develop our country's health care financing mechanism.

As the panel's report makes clear, we know that prevention, intervention, treatment, and recovery services are effective. We know, further, that providing timely and appropriate treatment actually saves health care dollars and reduces related social problems.

Our challenge is to provide leadership on this issue. We hope that community leaders in cities and towns across the country will document the need for services, and describe the consequences when these services are not part of everyone's health care benefit. To help community groups to get involved in this initiative, Join Together has produced additional educational materials that are available from its office. We further encourage the leaders of other national organizations to continue their own efforts.

Finally, the panel made a key point in this report that deserves a special notice, and a commitment. Prevention activities are a critical part of a comprehensive community strategy to reduce the harm from substance abuse. Indeed, the panel report discusses the cost effectiveness of funding prevention and suggests some mechanisms for providing funding. However, most prevention activities currently lie outside reimbursable health care.

Effective prevention services need stable long-term funding. Therefore, Join Together will devote its next national policy panel to the funding and organizing of prevention activities.

For her leadership and insight, I thank Mayor Whitmire. She and the members of the policy panel have generously devoted time, energy, and expertise to this report. On behalf of Join Together, and the community coalition leaders across the nation who inspired this study, I offer our gratitude. I also wish to acknowledge the support of the Robert Wood Johnson Foundation, and the Boston University School of Public Health, both of which continue to be critical to the Join Together mission.

Sincerely,

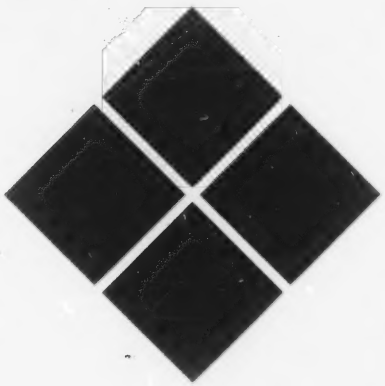
Calvin Hill

Calvin Hill
Chairman
Join Together National Advisory Committee

Health Reform for Communities:

Financing Substance Abuse Services

Recommendations
from a
Join Together Policy Panel



JOIN TOGETHER

A NATIONAL RESOURCE FOR COMMUNITIES FIGHTING SUBSTANCE ABUSE

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Comments from the Panel Chair

Kathryn J. Whitmire

Substance abuse continues to take a toll on America's communities. The cost is not always measured in dollars, it is also in a parent's worry, a spouse's pain, a neighbor's fear, and a friend's grief. We can, however, measure the societal costs — including the cost of health care, lost time and productivity in the workplace, and the enormous cost of drug-related crime and violence. The consequences of this nation's abuse of alcohol and other drugs are now costing us almost $150 billion per year.

During my tenure as mayor of the nation's fourth largest city, we formed a local coalition called Houston Crackdown to concentrate the community's efforts on combating the havoc caused by substance abuse in our city. We worked hard to support and expand the local programs providing treatment to those already suffering from addiction, while emphasizing prevention to reduce the demand for drugs and law enforcement to reduce the supply.

The good news is that treatment works, if it is available on a timely basis and combined with essential human services.

The bad news is that treatment doesn't work if it doesn't exist, or if it isn't provided in an effective manner.

Join Together surveyed community coalitions like Houston Crackdown across the nation, and found one of the biggest hurdles they face is the limited availability of treatment. Our Join Together panel was charged with finding a way to get over this hurdle so communities can succeed in conquering substance abuse.

This panel believes that the most effective way to guarantee that treatment is delivered in a cost-effective manner in every community is to assure that it is part of a basic health care insurance benefit available to all Americans.

The panel further believes that no universal health care program can be truly cost effective unless comprehensive substance abuse treatment is included. We're convinced that our country's health care bill can be significantly reduced by effective prevention and treatment of substance abuse.

When this panel began its work, it started with the 1990 comprehensive studies of alcohol and drug abuse treatment and recovery sponsored by the Institute of Medicine. The panel surveyed community coalitions, listened to professional and community leaders at a public hearing at the Marshall Heights Fighting Back program in Washington, D.C., and reviewed analyses of substance abuse treatment and heard proposals for reforming the country's health care system.

The panel's seven recommendations focus on paying for substance abuse treatment, and on getting our money's worth. We propose organizational principles to integrate substance abuse into the health care and human service network, to make it more cost-effective and to yield higher success rates.

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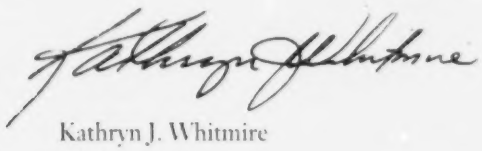
The panel now challenges communities across the country to address the issues raised in this report. The opportunity is here to document and illustrate our local concerns and help to fashion a health care system that will reduce the huge cost our nation now pays as the consequence of substance abuse.

I want to thank all of the members of the panel for their many hours of work on this project and their careful examination of this critical public policy issue. Each member brought to our deliberations their valuable experience, insight, and expertise from very diverse backgrounds. Their voices, individually and collectively, will be heard in this report and in the work ahead.



Kathryn J. Whitmire
Chair
Join Together National Policy Panel on Financing Substance Abuse Services

Financing Substance Abuse Services

Recommendations from a Join Together Policy Panel

As the nation seeks to restructure its health care system to provide effective care to all Americans and constrain rising health care costs, the time is ripe to ensure that necessary and appropriate substance abuse treatment and prevention services are also available and accessible to all Americans.*

Substance abuse and its profound economic, health, and social costs can be treated, prevented, and reduced. Substance abuse treatment has been demonstrated to be effective in reducing not only substance use, but also the costs associated with substance abuse. Moreover, there is widespread agreement that concerted prevention efforts can reduce the incidence of substance abuse, especially among adolescents.

Universal access to timely and appropriate substance abuse services must be a principal goal for communities and the nation. Today, an estimated 5 million persons need treatment for drug problems, and another 18 million require treatment for alcohol abuse. Yet in 1991, only 237,000 persons enrolled in drug treatment and 365,000 in alcohol treatment. An additional 210,000 are in treatment for both drug and alcohol problems. The consequences of substance abuse, left untreated, include poor health, family disintegration, employee absenteeism, lost productivity, and increased accidents, crime, and violence. No segment of society has been spared these effects.

The Join Together Policy Panel on Financing Substance Abuse Services urges communities and individuals to provide active leadership in supporting a national effort to include appropriate and accessible substance abuse services in health care reform.

Communities have been instrumental in promoting substance abuse prevention and treatment initiatives. They are best equipped to identify local substance abuse problems and design appropriate strategies to address those problems. Communities have been constrained in their efforts, though, by a lack of adequate, coordinated resources to confront substance abuse. As a result, in many areas of the country, substance abuse treatment and prevention services are in short supply, and many who need these services cannot obtain them when they need them.

The panel believes that the implementation of the recommendations of this report will reduce substance abuse-related costs in amounts far greater than the cost of providing the needed substance abuse services, and will have a measurable positive impact on communities grappling with the problems of substance abuse. These services should be an integral component of any health care reform effort aimed at containing health care costs and improving the health of the nation.

This report discusses and includes recommendations for financing and organizing substance abuse prevention programs. Recognizing the importance of prevention in reducing the harm from substance abuse, the panel encourages Join Together to consider a broad-based public policy review of the structure and funding of prevention activities in the nation's communities.

** The term "substance abuse" is used throughout to refer to the abuse of alcohol and other drugs.*

Substance abuse treatment services should be financed through the same sources that fund other health care benefits. This can be achieved by ensuring that substance abuse treatment is part of a standard health care benefit package guaranteed for all Americans. Under this benefit, persons with substance abuse problems would have universal access to an integrated managed system of services, in which they are matched with appropriate care, and supported by essential preventive and human services. By financing substance abuse treatment like other health care benefits, much of the fragmentation in financing that has resulted in the lack of coordinated delivery of substance abuse treatment can be averted.

Recommendation

Substance abuse treatment should be financed through the same sources that fund general health care.

To support health care coverage for all Americans, the panel recommends that sources of health care funding should include increased taxes on alcohol and tobacco.

Taxes on alcohol and tobacco have been demonstrated to reduce the consumption of these substances, particularly among adolescents. Lowered consumption will result in a decline in health problems and consequent costs associated with alcohol and tobacco use (e.g., liver disease, motor vehicle accidents, lung disease).

Revenues from these taxes should be used to fund health care, thus helping to offset some of the costs imposed on society as a result of alcohol and tobacco use.

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Recommendation

Prevention should be adequately financed through a combination of public and private sector funding sources.

The continuum of substance abuse services is not complete without prevention. Prevention is fundamental to reducing the need for substance abuse treatment and the costs associated with substance abuse. Communities should be encouraged to adopt and support a range of substance abuse prevention activities, in schools, worksites, religious organizations, and neighborhoods, targeted to address the particular needs and problems they confront.

Historically, there has been a separation between systems that deliver personal health care services, and those that deliver public health and preventive health services. The former was mostly privately delivered and financed (apart from the increasingly large public provision of such services over the past 27 years), while public health was organized, delivered, and financed primarily through government.

Growing evidence suggests that public health and other preventive services can contribute to significant reductions in health costs. Consequently, both private and public health insurance plans have increasingly provided coverage for more services considered "preventive," under the premise that this may eventually result in reduced requirements for personal health services. Health maintenance organizations, because they are responsible for the health of their subscribers, have often led the way, offering access to services such as smoking cessation, blood pressure and cholesterol screening, mammograms, well-baby checkups, and periodic comprehensive health assessments for adults. Physicians increasingly (but not frequently enough) screen patients about their health-related behaviors including drinking, smoking, and illicit drug use, and may informally counsel patients or even formally refer them to services that assist them in changing such behaviors.

Most preventive services — including substance abuse prevention — have not been incorporated into health plans, however, despite the supposition that this could "pay off" in terms of improved health and reduced health expenses. While the theoretical justification for incorporating substance abuse prevention initiatives into national health care reform are clear, there is virtually no research literature on which to base the formulation of recommendations. It will obviously be important for government to invest in this area of research in the near future, for it will be vital for appropriate preventive substance abuse interventions to be provided by a comprehensive national health system.

- This panel believes that substance abuse prevention should be explicitly supported and financed through an array of other sources (new and existing). These sources could include federal block grant funds, foundation funding, and private sector efforts in support of community prevention strategies.

The existing federal block grants should be strengthened and coordinated with funds from other federal, state, and local organizations, private businesses, and religious, civic, and educational organizations.

Prevention should continue to receive federal support such as that specified in the block grant. This federal support should be increased as a means of significantly decreasing the use of more costly treatment resources. Other public sector funds for prevention should be increased and coordinated with block grant funding.

Private sector resources should also be used to support prevention. These include corporate, foundation, religious, and not for profit institutions, all of which have invested in this arena, but which would be well served if prevention activities were expanded. These private funding sources would be more effective if their initiatives were better coordinated with each other and with public sector funders.

Proceeds from drug-related asset forfeitures and seizures should be available to enhance spending for prevention at local discretion.

Federal policies regarding the use of monies confiscated as part of a criminal drug proceeding appear to restrict the use of these funds at the local level primarily for law enforcement. While the availability of these funds has been extremely helpful for many localities in supporting local law enforcement, localities should have more flexibility in accessing and using a substantial portion of these funds to support other efforts to reduce the harm from substance abuse, such as community-based prevention programs.

Recommendation

The nation must make a commitment to adopt and enforce cost containment mechanisms to control the rise in health care costs throughout the health care system; substance abuse prevention and treatment in and of themselves are essential components of any overall health care cost containment strategy.

If substance abuse prevention efforts are successful, the need for substance abuse treatment will be reduced as will the costs associated with treating substance abuse and its medical, social, and criminal justice consequences. Similarly, effective treatment will have a measurable impact on future health care costs. The panel concludes that substance abuse prevention and treatment in and of themselves are important components of any overall health care cost containment strategy.

A national cost containment effort must include establishing and adhering to a general health care global budget. However, substance abuse services should not be isolated in a separate budget from other health care services.

The panel also recognizes that there are several other cost containment mechanisms that may be applied to substance abuse treatment as they are applied to other health care services that can enhance the cost-effectiveness of drug and alcohol treatment:

- **Managed care**, provided that those who are responsible for making service decisions are appropriately trained to make those decisions and operate independently of financial incentives that would affect the recommended treatment.

- The use of **uniform assessment and placement criteria** to assign patients to specific treatment services or programs. These criteria should be based on empirical research on which services are actually needed to sustain recovery for clients with specific problems. They should be administered by trained staff familiar with local treatment resources.

- **Performance rating** of programs or health plans, including data on long term client outcomes (adjusted for patient case mix), and client satisfaction. Performance information should be part of the package of information provided to consumers when they are selecting health care providers and/or plans.

All Americans should have access to substance abuse diagnosis and appropriate treatment when in need. In 1991, there were approximately one million persons in treatment. This figure is clearly below the widely accepted estimate that between 21 and 22 million individuals with alcohol or drug problems would benefit from treatment. Currently, individuals who need and want substance abuse treatment and related services often cannot or do not obtain those services because of waiting lists and insufficient system capacity to meet the demand for services. The National Association for State Alcohol and Drug Abuse Directors estimated in mid-1993 that nearly 75,000 individuals were waiting for treatment in programs that were operating at capacity.

Recommendation

There should be universal and timely access to substance abuse diagnosis and appropriate treatment services.

- **All Americans should be covered continuously for a standard set of health care benefits, including substance abuse treatment.**

  A fundamental component of health care reform should be that all Americans have access to a basic set of health benefits, including substance abuse treatment. Currently, the level of coverage for substance abuse treatment (and other health care services) varies by insurance plan and by state, and this coverage is not stable. Individuals gain and lose coverage as a result of changes in employment, health status, and family composition. Without adequate, continuous coverage, individuals cannot obtain appropriate, ongoing substance abuse treatment. Therefore, it is critical that all Americans remain covered for the same treatment services regardless of changes in their personal status to assure continuous access to needed services.

- **Individuals involved with the criminal justice system — incarcerated, on probation, or on parole — should be guaranteed the same standard health benefits, including substance abuse services, as all other Americans.**

  Since many individuals involved with the criminal justice system have alcohol and drug problems, the loss of comprehensive health care benefits that can result from an individual's involvement with the criminal justice system (e.g., incarcerated, on probation, or parole) is a particular concern. Drug and alcohol treatment should be made available throughout the same standard health care benefit available to all other Americans. Further, for individuals with alcohol or drug problems who are placed on probation or parole, enrollment and participation in a drug or alcohol treatment program should be made a condition of their probation or parole. Some jurisdictions have already used this approach successfully. Therefore, the panel recommends broader use of the criminal justice system as a means to ensure that substance abusers involved in criminal activity receive needed treatment.

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◆ **Interim treatment must be made available to individuals who must wait for admission to more intensive programs.**

For individuals whose access to the most appropriate treatment modality is delayed because of insufficient treatment capacity, interim treatment must be available. Interim treatment is necessary to ensure that individuals are engaged in the treatment process and are not lost to follow-up or discouraged by delays in placement.

No single substance abuse treatment modality is clearly more effective than any other treatment modality for all clients. The most appropriate and effective treatment for an individual depends on a host of factors, including the severity of an individual's addiction, the types of substances abused, the family and social support network, and the client's cultural background and socio-economic status.

Recommendation

A broad continuum of substance abuse treatment services must be available and accessible to all.

◆ **Substance abuse treatment services must be explicitly included as part of a standard benefit package proposed for health care reform.**

Health care reform should establish a standard benefit package for which all Americans will be guaranteed coverage, including substance abuse treatment services. As part of a standard benefit, substance abuse treatment should be financed through the same mechanisms and through the same sources as other health care services.

Covered treatment and rehabilitation services (as needed, based on standardized assessment criteria) should include**:

- evaluation, including diagnosis and referral
- detoxification, in a variety of settings
- residential treatment, both short-term and long-term
- hospitalizations, primarily for medical complications or associated psychiatric problems
- community outpatient treatment, including a range from brief counseling to day and evening treatment of varying intensity, as well as family therapy
- pharmacotherapeutic intervention, both short term for acute situations and long-term for maintenance
- clinical preventive services, including brief intervention conducted by primary care providers.
- case management
- relapse prevention services necessary for follow-up after treatment

**The following list is based, in part, on the recommendations of the Center on Addiction and Substance Abuse (CASA) presented in a briefing paper, March 7, 1993.

◆ **Substance abuse treatment should be subject to the same coverage criteria (e.g., limits) as other health services.**

As part of a standard set of benefits guaranteed for all Americans, substance abuse treatment should be subject to the same coverage criteria as other services in the package. Historically, mental health and substance abuse treatment services have been subject to arbitrary limits on the amount, duration, and scope of care that will be covered by private or public insurance. Many of these limits were established because of concerns that unrestricted coverage would result in over-utilization or inappropriate use of treatment services. Within a managed delivery system designed to prescribe and deliver services only as necessary and appropriate (as determined by qualified health professionals based on uniform criteria), however, the misuse of substance abuse treatment services should be no more likely than it is for other health services.

◆ **Coverage of substance abuse treatment services should include services provided by a range of trained, qualified professionals, including medical and non-medical personnel (e.g., counselors) in the most appropriate setting for the individual, including hospital and non-hospital settings.**

Substance abuse treatment is currently provided effectively by a range of medical and non-medical personnel in a variety of settings. However, access to many of these treatment services is restricted because there often is limited or no reimbursement available for treatment provided by non-medical personnel or in non-hospital (e.g., residential) settings. These limits have persisted despite evidence that, particularly for some individuals, non-medical providers and residential settings offer the most appropriate and effective treatment. In order to improve access to appropriate treatment services, coverage and reimbursement for services provided by non-medical personnel and/or in alternative, non-hospital settings must be available.

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The panel believes that the success and cost-effectiveness of treatment are likely to be substantially enhanced for many individuals by access to essential human services (e.g., outreach, child care, and job training). Effective case management is therefore fundamental to effective substance abuse treatment. Effective management of substance abuse treatment commences with the use of standard assessment tools to appropriately match clients with treatment, and entails active participation of a case manager throughout treatment to ensure that a client's medical and other service needs are met.

Recommendation

Substance abuse treatment should be managed and coordinated with essential human services to encourage the delivery of appropriate, cost-effective care.

- **Essential human services (e.g., outreach, transportation, child care, job training) needed by people with substance abuse problems must be available and accessible through linkages with substance abuse treatment.**

  Human services, such as outreach, child care, and transportation, have proven to be effective in engaging individuals in substance abuse treatment. Services that continue to support individuals and their families after the clinical segment of treatment has ended, such as education, job training, family counseling, and housing assistance, are considered integral to substance abuse treatment. In many cases, these services are the determining factor in the individual's ability to remain in treatment and enjoy a sustained recovery. Since these services are not likely to be part of the health care benefit package, explicit linkages with essential services must be established or enhanced. These linkages will ensure that the essential human services are available and accessible to those individuals for whom these services are critical to successful substance abuse treatment.

  Human services integral to the delivery of effective substance abuse treatment, but not included in the standard health care benefit, should be explicitly supported and financed through an array of other new and existing sources.

- **Substance abuse treatment services should be closely linked with mental health and other medical services to appropriately meet the needs of people with additional health problems.**

  Because many people with substance abuse problems have mental health and other medical problems, it is important that strong linkages are established between substance abuse treatment and other medical services to ensure that all health needs are met. Those with multiple diagnoses, such as substance abuse and depression, or substance abuse and HIV/AIDS, are often treated for one condition or the other, rather than for both conditions. The result is often the persistence of the untreated disorder and a decline, rather than an improvement, in the individual's health.

Recommendation

The standard health care benefits should cover the cost of clinical preventive education, brief intervention counseling, and/or referral for alcohol, tobacco, and other drug problems.

Primary care and first contact health care providers have more than 90 million outpatient clinical encounters each year in the United States. These physicians, nurse practitioners, and physician assistants are in the position to address the issue of substance abuse with patients who seek care for matters ranging from routine health maintenance in a primary care clinic to a traumatic injury in an emergency department. Relatively brief interventions, for example, have consistently been found to be effective in reducing alcohol and tobacco consumption and achieving substance abuse treatment referral. We must overcome the barriers, including lack of training and reimbursement, to the routine use of effective, inexpensive, and brief interventions for substance abuse disorders in medical practice.

- The panel endorses this view of brief intervention, and in light of the likely economic and social cost benefits, recommends that brief interventions in the clinical settings should be reimbursed as part of the standard health care benefit package. The panel further recommends that appropriate resources be made available to finance the training of clinical personnel to equip them to identify and provide brief intervention to persons with substance abuse problems.

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Substance Abuse Treatment and Health Care Reform

Health care reform is at the forefront of the domestic policy agenda. Numerous health care reform proposals have been introduced in Congress. The President has presented to Congress a formal proposal — based on the findings of a White House Task Force — dedicated to formulating a comprehensive national strategy for reform. The debate over fixing the nation's health care system is well underway. It will not conclude until every state has implemented its own mechanism for financing health care.

For communities with alcohol and drug abuse problems, health care reform poses particular challenges. Health care reform has largely focused on improving access to a minimum standard of care for the vast majority of healthy Americans who do not require extensive health services except for periodic acute episodes of illness. As a result, the special problems of people with severe or chronic health conditions, such as substance abuse, who require ongoing or extensive services may not be addressed adequately.

While health care reform is being determined, first at the federal and subsequently at the state levels, the Join Together Policy Panel on Financing Substance Abuse Services intends that this report will illuminate and provoke discussion of the following points in communities across the country:

- Should "treatment on demand" be a national goal?
- How should alcohol and drug abuse treatment be addressed specifically in health care reform?
- To what extent should substance abuse treatment services be defined (e.g., as specific services or service types) under reform?
- How can cost containment mechanisms, such as limits on utilization and managed care, be appropriately designed to minimize adverse impact on substance abusers?
- What provisions are necessary to ensure that treatment is available to those who need it?

The Problems of Alcohol and Drug Abuse in the U.S.

Concern about alcohol and drug abuse has escalated to become a leading public health issue in the U.S. There is agreement that the current rates of alcohol and drug abuse are unacceptably high and have serious consequences.

Prevalence of Substance Abuse

Alcohol and drug problems have been defined as chronic, relapsing disorders, with complex biological, psychological, and social causes. The prevalence of substance abuse is difficult to measure. Household surveys (e.g., the National Household Survey of Drug Abuse) shed some light on the scope of the drug use within the total population; however, these surveys may underestimate drug use because many heavy drug users do not live in households, and because many individuals may be reluctant to report use of illicit drugs (ONDCP, 1991). Other targeted studies have attempted to estimate the prevalence of substance use in special populations (e.g., pregnant women, incarcerated persons).

Estimates from the 1991 National Household Survey on Drug Abuse indicate that about 12.6 million people used

12.6 million people used illicit drugs in 1991, including about 1.9 million people who used cocaine.

Almost 43 million people use alcohol at least once a week

any illicit drug in the 30 days prior to the survey, including about 1.9 million people who used cocaine. About 1.6 million people reportedly used cocaine 12 or more times in the past year. Almost 43 million people used alcohol at least once a week in the year prior to the survey. Recent estimates of heroin use suggest that there are about 0.7 million heroin users (ONDCP, June 1991).

Recognizing that many persons who use alcohol and other drugs do not require treatment, recent studies have attempted to identify the need for substance abuse treatment within the population (Gerstein and Harwood, 1990). A study by the Institute of Medicine (IOM) estimated the need for treatment among individuals who had used drugs other than alcohol in the past 30 days on a scale ranging from an "unlikely" need for treatment to a "clear" need for treatment. As shown in Exhibits 1 and 2, these estimates suggest that there are about 5 million persons in clear or probable need of treatment for drug [non-alcohol] problems in the U.S., including about 1.1 million individuals who are clients of the criminal justice system (Gerstein and Harwood, 1990). Comparable estimates have been developed for internal use by DHHS. An additional 18.5 million persons require treatment for alcohol (NIAAA, 1989). About 12.6 million persons per month illicitly use drugs, and another 100 million use alcohol, but do not need treatment to stop.

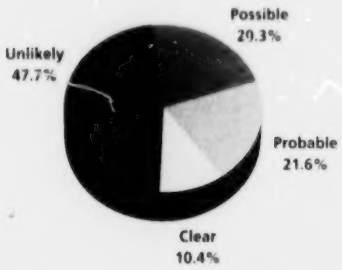
Of those who use alcohol, 18.5 million persons require treatment for alcohol (NIAAA, 1989).

The prevalence of substance abuse and the need for treatment varies among population groups. Data from the 1988 National Household Survey on Drug Abuse estimate that two thirds of the population who clearly or probably need treatment were male and predominately young adults (age 18 to 34) (Gerstein and Harwood, 1990). About 9.3 million women ages 15 to 35 years were estimated to have used an illicit drug at least once in the past year, including 4.9 million who had used an illicit drug within the past month (Gerstein and Harwood, 1990). Of those who reported use in the past month, 35 percent were estimated to be clearly or probably in need of drug treatment.

In 1990, almost 750,000 persons were in drug treatment (NDATUS, 1990). Over two-thirds of clients were male, and almost two-thirds were white (non-Hispanic). In general, however, treatment clients are not characterized by a common set of demographics or problems. They vary in age, social and economic background, insurance status, number and type of drugs abused, health status and psychological well-being. Some have lengthy histories of addiction and treatment, while others are entering treatment for the first time in the early stages of dependence.

Motivations for treatment are similarly diverse. Studies have found, however, that treatment is often sought when an individual faces uncontrollable and urgent problems related to physical or mental health, or other negative consequences, such as imprisonment. A 1988 study found that as many as 90 percent of people in treatment did not seek it on their own; rather, they were compelled to do so by family, employment, or legal pressure, or some combination thereof (ONDCP, 1990). For example, many substance abuse treatment clients are in treatment as a result of referral by the criminal justice system as a diversion

EXHIBIT 1
Estimated Need for Treatment, 1988



Source: Institute of Medicine analysis of data from the 1988 National Household Survey on Drug Abuse conducted by the Research Triangle Institute; Innes (1988); Flanagan and Jamieson (1988); Greenfeld (1989); and Institute of Medicine (1988b).

from incarceration (Hubbard, 1989), or entered treatment while on probation or parole. Indeed, pressure from the criminal justice system is reportedly the strongest motivation for seeking publicly provided treatment (Gerstein and Harwood, 1990).

Consequences of Alcohol and Drug Abuse

The widespread concern about substance abuse is largely related to the health, economic, and other costs associated with alcohol and drug abuse.

Health and Social Consequences

There are substantial health consequences of substance abuse including liver disease, GI problems, nutritional disorders, and fetal alcohol syndrome in children born to alcohol abusing women. It has been estimated that almost one-third of all AIDS cases are related to intravenous drug use, and that 70 percent of all pediatric AIDS cases are related to maternal exposure to HIV through drug use or sex with a drug user (Legal Action Center, 1993). There is growing evidence that perinatal substance abuse results in poor birth outcomes, including low-birth weight, and many suspect that perinatal substance abuse is responsible for developmental delay and disability in young children (DHHS, 1992). In addition, substance abusers often manifest psychological and emotional instability, and frequently suffer from a variety of mental disorders, such as depression (persons identified as substance abusers and also determined to be mentally ill are referred to as "dual diagnosed").

Substance abuse has many indirect social consequences for family members, employers, and the public at large. Substance abusers often shirk responsibilities, and are not fully productive at work. High rates of accidents and absenteeism on the job are also reported among substance abusers. Furthermore, alcohol and drug abuse are associated with motor vehicle and other accidents, and violent and acquisitive crime. One study found that 41 percent of all treatment clients examined admitted to have committed at least one "predatory crime" (e.g., aggravated assault, robbery, burglary) in the year prior to admission (Hubbard, et al., 1989). Moreover, criminal activity was found to be more likely among poly-drug users with serious abuse patterns, than among those with alcohol/marijuana, or minimal use patterns (Hubbard et al., 1989).

EXHIBIT 2
Estimated Need for Drug Treatment (in thousands) Among Surveyed Adult and Adolescent Populations 1987-1988

POPULATION	TOTAL	THOSE WHO NEED TREATMENT
Household	198,000	
Clear need		1,500
Probable need		3,100
Homeless (sheltered, street, and transient)	1,225	170
Criminal justice clients		
Correctional custody	925	320
Probation and parole	2,600	730
Pregnancies (live births)	3,875	105
(Less overlaps)		(-470)
Total needing treatment		5,455

Note: The estimated need for treatment among the 1988 household drug-consuming population (14.5 million individuals in the household population who had used drugs at least once in the past 30 days).

Source: Institute of Medicine analysis of data from the 1988 National Household Survey on Drug Abuse, performed by Research Triangle Institute for the National Institute on Drug Abuse.

The total economic costs of substance abuse in 1985 were estimated to be over $114 billion, and projected to be $144 billion in 1988

Economic Costs

The costs associated with alcohol and drug abuse include the direct costs of substance abuse treatment, expenditures associated with treating the consequences of alcohol and drug abuse (e.g., liver disease, HIV infection), reduced or lost productivity in the workplace, and costs associated with crime and motor vehicle and other accidents related to substance abuse. The total economic costs of substance abuse in 1985 were estimated to be over $114 billion, and projected to be $144 billion in 1988 (Rice et al., 1990).

Of the $114 billion, $70.3 billion (62 percent) were costs related to alcohol abuse, and $44.1 billion (38 percent) were related to drug abuse. Direct costs related to alcohol and drug abuse (e.g., costs of treatment and prevention for alcohol and drug abuse and costs related to treating comorbidities associated with substance abuse) amounted to 10 percent of total costs of alcohol abuse, and 5 percent of total costs for drug abuse, for a total of $8.9 billion. The costs of AIDS and fetal alcohol syndrome alone were estimated to be $2.6 billion, about 2 percent of the total economic costs of substance abuse (Rice et al., 1990). Other related costs, including costs of crime and motor vehicle accidents, accounted for $42 billion (Rice et al., 1990). The remaining $60 billion are indirect costs of morbidity and mortality. The morbidity costs include the value of goods and services lost by individuals unable to perform their usual activities because of alcohol and drug abuse problems, or are unable to perform them at a level of full effectiveness (e.g., income loss), while mortality costs account for the present value of future output (i.e., earnings) lost due to premature death as a result of alcohol and drug abuse (Rice et al., 1990).

Overview of the Substance Abuse Treatment System

The alcohol and drug abuse treatment system operates as a specialized delivery system, operating parallel to the general health system. The overall substance abuse treatment system has experienced changes in the past dozen years in response to efforts to expand system capacity and to the evolution of financing mechanisms to support substance abuse treatment services. Increasingly, however, concerns about demonstrated treatment effectiveness are driving decisions about the types of treatment that are provided and financed.

Currently, alcohol and drug abuse treatment services are delivered in what are effectively two separate systems: a public tier and a private tier. Each tier is unique and can be characterized by the population served, features of the services provided, and its sources of financing.

The Public and Private Tiers

The public tier is the only point of access to treatment for those who lack private insurance or the financial resources to utilize private treatment. The individuals dependent upon the public tier are predominantly uninsured, poor, and unemployed, most of whom have many other problems, such as diminished general health, poor education, and family breakdown, and many of whom are likely to have records of criminal activity and involvement with the criminal justice system (Gerstein and Harwood, 1990). Overall, persons served by the public tier

seem to have higher-severity problems than those treated in the private tier.

The public treatment system comprises publicly owned and publicly subsidized private non-profit treatment facilities and programs, including prison programs that deliver services directly to clients. The services provided by the public treatment system range from very short-term detoxification to long-term rehabilitation services, with and without medications. Caseloads in public programs tend to be higher than in the private sector, largely as a result of limited resources that must be stretched to cope with growing demands for services.

Capacity in the publicly funded sector changed modestly in the 1980s while the number of privately funded sector treatment units (including private for-profit and not-for-profit hospital units) more than doubled (Gerstein and Harwood, 1990). Estimates from the 1991 National Drug and Alcoholism Treatment Unit survey show about 224,000 clients in publicly owned treatment programs with a total treatment capacity of 262,000; about 585,000 individuals were in privately owned treatment programs with a total capacity of 737,000 (NIDA/NIAAA, 1991).

Public-tier treatment programs operate at close to full capacity, particularly in methadone and outpatient treatment facilities (Gerstein and Harwood, 1990). The National Association of State Alcohol and Drug Abuse Directors has collected data that show nearly 75,000 individuals are on lists waiting for openings in treatment programs that are operating at capacity. Outpatient treatment programs alone provided services to three-quarters of all individuals in alcohol and drug treatment, suggesting the critical role of the public treatment system in supporting outpatient treatment for both alcohol and drug abuse.

The private tier of substance abuse treatment has evolved over the past two decades to accommodate privately insured individuals as well as those who have the resources to pay for services out-of-pocket. In contrast to the public tier, private-tier clients tend to be working class, middle class, and upper-class, and have low-to-medium severity problems (Gerstein and Harwood, 1990). Private-tier providers generally comprise for-profit private programs and hospital based non-profit programs.

Estimates for 1991 show that public sources (including Medicare, Medicaid, and direct government appropriations) paid $2.8 billion of the $4.1 billion spent on substance abuse treatment in that year. Private insurance paid $880 million, and client out-of-pocket payments totaled $446 million.

Substance Abuse Services and Expenditures

Studies currently underway estimate that the 1993 treatment expenditures for substance abuse treatment is approximately $6.7 billion. (These costs do not begin to cover the treatment of substance abuse-related illnesses, such as mental illness, physical health problems, and a broad range of injuries, including the deliberate results of acts of violence.) Again, studies show that these related health problems decline when substance abuse is treated — or prevented.

Any proposal to reform care must look at the cost of that care. Estimates for cost increases for various reforms range from minimal to as much as $3.4 billion per year. These projections are based on the present treatment system, and do not account for changes in quality or intensity of services.

The differences in expenditures reflect the status of the system under which health care would be delivered, viz.,

EXHIBIT 3
Preferred Sites or Types of Treatment for Selected Categories of Drug Treatment Clients

Type of Service Needed or Client Characteristics	Inpatient/Residential		Outpatient/Ambulatory	
	Hospital	Nonhospital	Methadone	Counseling
Drug Overdose	P	X	X	X
Detoxification	X	S	P	P
Rehabilitation	X	P	P	S
High Criminality	X	S	P	P
Low Criminality	X	S	P	P
Job Jeopardy only	X	S	X	P
Adolescent	X	P	X	X
Domiciliary (permanent drug induced organic brain syndrome)	X	P	X	X

P — Primary site/modality of the most appropriate treatment

S — Secondary or less likely site for treatment (neverless, for some clients this may be the primary or preferred site owing to their specific circumstances or needs

X — Generally inappropriate site/modality for this type of client

SOURCE: Gerstein and Harwood, Eds. Treating Drug Problems, Volume I, National Academy Press, 1990.

whether the health coverage would be private, public, or a combination of the two. Further differences in costs are reflected in the various levels of proposed clinical and social support services, which research suggests improves outcomes, and the costs associated with the length and site of treatment.

It seems fair to suggest that if one accepts the operating assumption that use of services would increase 50 percent under a universal benefit, the costs of the panel's recommendations would be closer to the higher estimate. This is because the panel outlines increased services as well as universal and timely access to appropriate care.

Clients with longer retention in treatment on average have better outcomes than clients with short treatment stays.

Effectiveness of Substance Abuse Treatment

Although substance abuse is considered by many a chronic illness prone to relapse, the outcome data from treatment programs during the past decade shows that a single episode of treatment can reduce alcohol and drug use, reduce family problems, reduce related health problems, reduce involvement with the criminal justice system, and increase productivity in the workplace.

The Treatment Outcome Prospective Study (TOPS), published in 1989, followed 10,000 individuals in 10 cities across the country. Based on this and other studies, researchers have compared the annual costs of treatment, ranging from $3,000 to $14,600 per person, depending upon the treatment program, to the annual costs of ignoring treatment needs, including: incarceration costs of up to $50,000 per inmate, and cost of AIDS treatment, now approximately $100,000 per patient annually. The comparison shows that the benefit-cost ratio of drug treatment programs is 11.54. This means that for every dollar spent for drug treatment services, $11.54 in related societal costs are saved.

There is general agreement (if not consensus) about appropriate matching of drug clients to treatment in the public tier of providers. For example, a basic outline of criteria for matching types of clients with types of treatment was published by the Office of National Drug Control Policy in a White Paper. Previously, the Institute of Medicine study on drug treatment characterized different types of treatment as being preferred, secondary, or inappropriate

cites of treatment for patients presenting with several general patterns of drug problems (Exhibit 3) (Gerstein and Harwood, 1990).

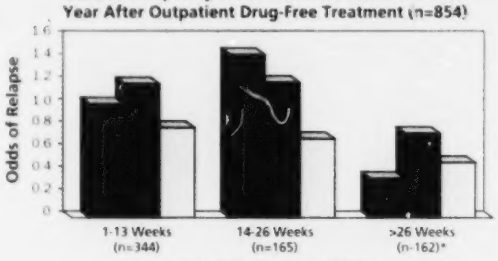
Research on the public drug treatment system has found that clients with longer retention in treatment on average have better outcomes than clients with short treatment stays. Exhibit 4 presents the findings of one study that demonstrates how the odds of relapse decline with increased time in treatment, regardless of treatment modality (Hubbard, et al, 1989). In addition to reductions in drug use, researchers have also documented a substantial reduction in criminal activity among program clients, particularly during treatment (Hubbard et al., 1989). Less is known, however, about the extent of changes in employment and psychological well-being associated with treatment participation (Hubbard, et al., 1989). Furthermore, few studies have examined treatment outcomes in the private substance abuse treatment system. The applicability of the results from public programs to the private sector depends on the extent to which private-tier and public-tier clients are treated in similar settings or programs, and share the same characteristics in terms of types of substances abused, severity of abuse, and other factors. In general, however, there is substantial controversy over the effectiveness of short- and medium-duration treatments that form the basis of the private system of substance abuse treatment.

Critical Issues for Substance Abuse Treatment

The inclusion of comprehensive substance abuse treatment has not been explicitly assured in health care reform proposals. As the debate proceeds, it will be important to examine emerging health care reform proposals to determine the potential implications for

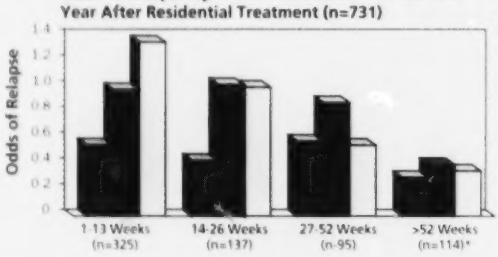
EXHIBIT 4

Odds of Relapse by Treatment Duration in the First Year After Outpatient Drug-Free Treatment (n=854)

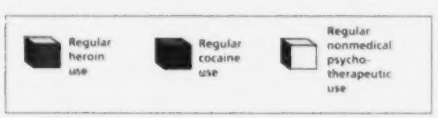


*p< 05 for regular nonmedical psychotherapeutic use > 26 weeks post treatment

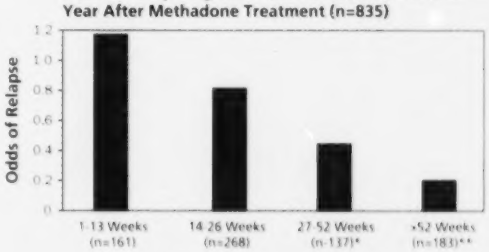
Odds of Relapse by Treatment Duration in the First Year After Residential Treatment (n=731)



* p< 05 for regular heroin use >52 weeks post-treatment
p< 01 for regular nonmedical psychotherapeutic use >52 weeks post treatment



Odds of Relapse by Treatment Duration in the First Year After Methadone Treatment (n=835)



* p< 05 for regular heroin use >52 weeks post treatment
* p< 001 for regular heroine use after long-term maintenance

SOURCE: Hubbard, et. al., Drug Abuse Treatment, *1989.*

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the substance abusing population and substance abuse treatment. In particular, there are five components of health care reform that present important questions for coverage of substance abuse treatment: coverage, services, delivery system structure, financing, and cost containment.

- **Coverage**. Who is covered? Are there shifts in coverage? Are there mechanisms for ensuring that populations that may be difficult to reach — such as the homeless — actually obtain coverage and/or services?

While universal coverage is clearly an important goal of reform, universal coverage may not actually be achieved unless issues related to how to ensure coverage are addressed. A related issue is whether continuity of coverage is maintained and how. If reform results in distinct private and public insurance programs, the extent to which persons currently treated in the public (or private) substance abuse treatment systems would instead be covered in the private (or public) system should be examined.

- **Benefits.** What services are included in a minimum benefit package? What limits are there on services? To what extent is a private supplemental insurance market or a public direct-service system established to support services not included in the minimum benefit package?

Determining what will (or will not) be included in a standard uniform benefit package requires balancing coverage and costs. A broader benefit package will be more expensive; however, a more narrow package is more likely to exclude services needed by some individuals and may represent a reduction in benefits for persons currently covered for alcohol and drug abuse treatment. For example, many states currently mandate that insurers offer or provide substance abuse treatment benefits. About 97 percent of employees insured in medium and large firms have some alcohol abuse treatment benefits, and about 96 percent have drug abuse treatment benefits (BLS, 1990). Of these, all have coverage for inpatient detoxification, and about two-thirds have coverage for inpatient rehabilitation. Among those with coverage, about 60 percent are covered for outpatient care. Coverage had day limits for 40 percent of those with inpatient benefits, and for about 20 percent of those with outpatient coverage. State Medicaid programs vary on the level of substance abuse treatment services covered. The extent to which substance abuse treatment services (and mental health) are covered explicitly under a uniform benefit package will have major implications for the availability and access to substance abuse treatment services. Limits on coverage, including cost-sharing, payment maximums, and encounter limits, will influence the types of treatment that are available to many individuals and the extent to which persons will have to pay for care out-of-pocket or rely on a public direct-service system.

- **Delivery System**. Are there provisions for restructuring the delivery system? To what extent are managed care models (i.e., managed care protocols, such as utilization review, and managed care structures, such as health maintenance organizations) the basis for delivery system reform?

Health care delivery system reforms that focus on providing more appropriate and coordinated care have gained increased attention because of the current system's

fragmentation, duplication, and inefficiency. Mechanisms for "managing care," such as utilization review, pose particular problems for people with substance abuse problems since they are primarily cost-containment measures. Delivery system reforms with managed care components must be carefully examined to determine whether they are appropriately designed to meet the often extensive service needs of the substance abusing population.

- **Financing.** How is the system financed? Are there shifts in financing responsibility? The critical issue for substance abuse treatment is the extent to which health care reform shifts the financing burden for treatment toward or away from existing public direct-service programs.

If coverage for a broad range of substance abuse treatment services is included in a uniform basic benefit package, it is likely that fewer individuals will rely on the public system for treatment (although covered services may still be available through public providers). However, if alcohol and drug abuse treatment are excluded from the basic package, or subject to rigorous limits, there will continue to be a great demand for public financing of substance abuse treatment for those without the means to purchase care out-of-pocket or with supplemental insurance.

- **Cost Containment.** What are the provisions for cost containment? Do cost containment provisions apply differently to the public and private sectors?

The public substance abuse treatment system has always been subject to "global budgets" of federal and state appropriations. Health care reform is likely to include an assortment of cost containment mechanisms in both the public and private sectors, ranging from direct and indirect methods for controlling health care spending by controlling use (e.g., through managed care) and by controlling price (e.g., regulating provider payment). Like delivery system reforms, some cost-containment mechanisms could create access barriers for persons with substance abuse problems, as providers may be discouraged from offering the extensive and expensive care that the most severe or chronic substance abusers require.

The challenge for health care reform is to adequately address the special needs of populations that may require services above and beyond the expected "average," such as people with alcohol and drug abuse problems and mental illness. The challenge for the substance abuse treatment system is to be prepared to accommodate a shifting burden of clients and resources. Health care reform offers the opportunity to diminish the distinction between the public and private tiers and improve the availability of treatment. However, to take advantage of this opportunity, it will be important to recognize that the role of the public sector in providing and supporting substance abuse treatment is likely to continue to be necessary as long as system incentives discourage intensive and long-term treatment of the most severely or chronically ill, particularly in the private tier.

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If you would like to sponsor a community meeting to educate citizens and groups about funding for substance abuse services in national health care reform, please contact Join Together at the address below.

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